STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF: [redacted],

Claimant

Reg. No.: 2009-10221
Issue No.: 2009, 4031
Case No.: [redacted]
Load No.: [redacted]
Hearing Date:
April 15, 2009
Oscoda County DHS

ADMINISTRATIVE LAW JUDGE: Colleen M. Mamelka

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon the Claimant's request for a hearing. After due notice, a telephone hearing was conducted from Detroit, Michigan on April 15, 2009. The Claimant appeared and testified. The Claimant was represented by [redacted]. [redacted] appeared on behalf of the Department. At the Claimant's request, the record was extended to allow for the submission of further medical evidence.

The additional medical information was received, reviewed, and entered into the record. This matter is now before the undersigned for final decision.

ISSUE

Whether the Department properly determined that the Claimant was not disabled for purposes continued entitlement to Medical Assistance ("MA-P") and the State Disability Assistance ("SDA") benefits?

FINDINGS OF FACT

The Administrative Law Judge, based on the competent, material and substantial evidence on the whole record, finds as material fact:

1. On November 17, 2008, the Claimant submitted an application for public assistance seeking MA-P and SDA benefits.
2. On December 5, 2008, the Medical Review Team ("MRT") determined the Claimant's impairment did not prevent employment for 90 days or more for SDA purposes, and finding the Claimant capable of performing other work for MA-P purposes. (Exhibit 1, p. 107-08)
3. On December 11, 2008, the Department sent the Claimant an eligibilty notice informing him he was found not disabled. (Exhibit 1, p. 109-10, 112)
4. On December 16, 2008, the Department received the Claimant's written request for hearing protesting the determination that he was found not disabled. (Exhibit 1, p. 113)
5. On February 3, 2009, the State Hearing Review Team ("SHRT") found the Claimant capable of performing other work thus not disabled. (Exhibit 2)
6. The Claimant's alleged physical disabling impairment(s) are due to chronic back with degenerative disc disease, neck and shoulder pain, knee pain, arthritis, hearing loss, chest pain, and skin rash.
7. The Claimant's alleged mental disabling impairments are due to anxiety, depression, and sleep disorder.
8. At the time of hearing, the Claimant was 38 years old with a [redacted] birth date; was 5' 10" and weighed approximately 190 pounds.

9. The Claimant is high school graduate with some college, and has as a Correctional Officer, Firefighter, and Military Police Officer.

10. The Claimant's impairment(s) have lasted, or are expected to last, continuously for a period of 12 months or longer.

CONCLUSIONS OF LAW

The Medical Assistance ("MA") program is established by Subchapter XIX of Chapter 7 of The Public Health & Welfare Act, 42 USC 1397, and is administered by the Department of Human Services ("DHS"), formally known as the Family Independence Agency, pursuant to MCL 400.10 *et seq* and MCL 400.105. Department policies are found in the Program Administrative Manual ("PAM"), the Program Eligibility Manual ("PEM"), and the Program Reference Manual ("PRM").

Disability is defined as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. 20 CFR 416.905(a) The person claiming a physical or mental disability has the burden to establish it through the use of competent medical evidence from qualified medical sources such as his or her medical history, clinical/laboratory findings, diagnosis/prescribed treatment, prognosis for recovery and/or medical assessment of ability to do work-relate activities or ability to reason and make appropriate mental adjustments, if a mental disability is alleged. 20 CRF 413.913 An individual's subjective pain complaints are not, in and of themselves, sufficient to establish disability. 20 CFR 416.908; 20 CFR 416.929(a) Similarly, conclusory statements by a physician or mental health professional that an individual is disabled or blind, absent supporting medical evidence, is insufficient to establish disability. 20 CFR 416.929(a)

When determining disability, the federal regulations require several factors to be considered including: (1) the location/duration/frequency/intensity of an applicant's pain; (2) the type/dosage/effectiveness/side effects of any medication the applicants takes to relieve pain; (3) any treatment other than pain medication that the applicant has received to relieve pain; and (4) the effect of the applicant's pain on his or her ability to do basic work activities. 20 CFR 416.929(c)(3) The applicant's pain must be assessed to determine the extent of his or her functional limitation(s) in light of the objective medical evidence presented. 20 CFR 416.929(c)(2)

In order to determine whether or not an individual is disabled, federal regulations require a five-step sequential evaluation process be utilized. 20 CFR 416.920(a)(1) The five-step analysis requires the trier of fact to consider an individual's current work activity; the severity of the impairment(s) both in duration and whether it meets or equals a listed impairment in Appendix 1; residual functional capacity to determine whether an individual can perform past relevant work; and residual functional capacity along with vocational factors (i.e. age, education, and work experience) to determine if an individual can adjust to other work. 20 CFR 416.920(a)(4); 20 CFR 416.945

If an individual is found disabled, or not disabled, at any step, a determination or decision is made with no need evaluate subsequent steps. 20 CFR 416.920(a)(4) If a determination cannot be made that an individual is disabled, or not disabled, at a particular step, the next step is required. 20 CFR 416.920(a)(4) If an impairment does not meet or equal a listed impairment, an individual's residual functional capacity is assessed before moving from step three to step four. 20 CFR 416.920(a)(4); 20 CFR 416.945 Residual functional capacity is the most an individual can do despite the limitations based on all relevant evidence. 20 CFR 945(a)(1) An individual's

residual functional capacity assessment is evaluated at both steps four and five. 20 CFR 416.920(a)(4) In determining disability, an individual's functional capacity to perform basic work activities is evaluated and if found that the individual has the ability to perform basic work activities without significant limitation, disability will not be found. 20 CFR 416.994(b)(1)(iv) In general, the individual has the responsibility to prove disability. 20 CFR 416.912(a) An impairment or combination of impairments is not severe if it does not significantly limit an individual's physical or mental ability to do basic work activities. 20 CFR 416.921(a) The individual has the responsibility to provide evidence of prior work experience; efforts to work; and any other factor showing how the impairment affects the ability to work. 20 CFR 416.912(c)(3)(5)(6)

In addition to the above, when evaluating mental impairments, a special technique is utilized. 20 CFR 416.920a(a) First, an individual's pertinent symptoms, signs, and laboratory findings are evaluated to determine whether a medically determinable mental impairment exists. 20 CFR 416.920a(b)(1) When a medically determinable mental impairment is established, the symptoms, signs and laboratory findings that substantiate the impairment are documented to include the individual's significant history, laboratory findings, and functional limitations. 20 CFR 416.920a(e)(2) Functional limitation(s) is assessed based upon the extent to which the impairment(s) interferes with an individual's ability to function independently, appropriately, effectively, and on a sustained basis. *Id.;* 20 CFR 416.920a(c)(2) Chronic mental disorders, structured settings, medication, and other treatment and the effect on the overall degree of functionality is considered. 20 CFR 416.920a(c)(1) In addition, four broad functional areas (activities of daily living; social functioning; concentration, persistence or pace; and episodes of decompensation) are considered when determining an individual's degree of functional

limitation. 20 CFR 416.920a(c)(3) The degree of limitation for the first three functional areas is rated by a five point scale: none, mild, moderate, marked, and extreme. 20 CFR 416.920a(c)(4) A four point scale (none, one or two, three, four or more) is used to rate the degree of limitation in the fourth functional area. *Id.* The last point on each scale represents a degree of limitation that is incompatible with the ability to do any gainful activity. *Id.*

After the degree of functional limitation is determined, the severity of the mental impairment is determined. 20 CFR 416.920a(d) If severe, a determination of whether the impairment meets or is the equivalent of a listed mental disorder. 20 CFR 416.920a(d)(2) If the severe mental impairment does not meet (or equal) a listed impairment, an individual's residual functional capacity is assessed. 20 CFR 416.920a(d)(3)

As outlined above, the first step looks at the individual's current work activity. An individual is not disabled regardless of the medical condition, age, education, and work experience, if the individual is working and the work is a substantial, gainful activity. 20 CFR 416.920(a)(4)(i) In the record presented, the Claimant is not involved in substantial gainful activity and last worked in April of 2008. Accordingly, the Claimant is not ineligible for disability under Step 1.

The severity of the Claimant's alleged impairment(s) is considered under Step 2. The Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairments. In order to be considered disabled for MA purposes, the impairment must be severe. 20 CFR 916.920(a)(4)(ii); 20 CFR 916.920(b) An impairment, or combination of impairments, is severe if it significantly limits an individual's physical or mental ability to do basic work activities regardless of age, education and work experience. 20 CFR

916.920(a)(4)(ii); 20 CFR 916.920(c) Basic work activities means the abilities and aptitudes necessary to do most jobs. 20 CFR 916.921(b) Examples include:

1. Physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;

2. Capacities for seeing, hearing, and speaking;

3. Understanding, carrying out, and remembering simple instructions;

4. Use of judgment;

5. Responding appropriately to supervision, co-workers and usual work situations; and

6. Dealing with changes in a routine work setting.

Id. The second step allows for dismissal of a disability claim obviously lacking in medical merit. *Higgs v Bowen*, 880 F2d 860, 862 (CA 6, 1988). The severity requirement may still be employed as an administrative convenience to screen out claims that are totally groundless solely from a medical standpoint. *Id.* at 863 *citing Farris v Sec of Health and Human Services*, 773 F2d 85, 90 n.1 (CA 6, 1985) An impairment qualifies as non-severe only if, regardless of a claimant's age, education, or work experience, the impairment would not affect the claimant's ability to work. *Salmi v Sec of Health and Human Services*, 774 F2d 685, 692 (CA 6, 1985)

In the present case, the Claimant asserts physical and mental disability based chronic back with degenerative disc disease, neck and shoulder pain, knee pain, arthritis, hearing loss, chest pain, skin rash, anxiety, depression, and sleep disorder.

On [redacted], the Claimant presented to the emergency room after a slip and fall incident while at work. The physical examination revealed bilateral paralumbar discomfort. The Claimant was prescribed ibuprofen and discharged.

The following day, the Claimant went back to the emergency room with complaints of continued low back pain. X-rays were normal and the Claimant was discharged with the diagnosis of low back pain.

On [redacted], the Claimant sought treatment for his low back pain. The physical examination was unremarkable and the Claimant was prescribed medication for pain.

On [redacted], the Claimant sought treatment for low back pain and rash. The physical examine revealed bilateral lower paraspinal muscle tenderness with normal gait. The Claimant was prescribed a muscle relaxer and pain medication.

On [redacted], the Claimant sought treatment for continued back pain. The Claimant who previously participated in physical therapy, was prescribed pain medication, muscle relaxer, and physical therapy. An MRI was to be scheduled if no improvement was found.

The Claimant attended a 12-week session of physical therapy beginning [redacted]. Physical therapy was discontined after [redacted] due to new MRI findings.

On [redacted], the Claimant attended a comprehensive physical examination which was unremarkable noting normal gait and posture with no malalignment, tenderness, or massess in any extremity.

On [redacted], the Claimant sought treatment for his back pain. The Claimant's pain increased after a fall at work. As a result, the Claimant was restricted to lifting no more than 25 pounds.

On [redacted], the Claimant attended a follow-up examination for back pain. Due to the chronic nature of the pain, a MRI was recommended. The Claimant was however, cleared for light-duty work without restriction.

On [redacted], an MRI of the lumbar spine without contrast was performed and compared with x-rays from [redacted]. The MRI impression was "highly suspicious for bilateral spondylolysis at the L4-5 level" but without evidence of associated spondylolisthesis. Further, broad-based right paracentral and right far lateral disc protrusion at the L4-5 level causing moderate right lateral recess narrowing and mild neural foraminal narrowing was documented as well as a small central disc protrusion at the L5-S1 level.

On [redacted], the Claimant attended a follow-up evaluation which included a rash on his stomach and a lesion on his back. The Claimant's therapeutic options were referred for consultation. The Claimant was limited to light duty work.

On [redacted], the Claimant attended a follow-up examination for his back pain. The Claimant was to be unable to work due to lumbar degenerative disc disease with associated severe pain. No significant improvement from physical therapy was noted. The Claimant's pain medication was increased.

On [redacted], the Claimant attended a neurosurgical consultation. The MRI was reviewed noting a break in the posterior elements at the oars interacrticularis bilaterally, consistent with spondylolysis. No significant canal compromise, lateral recess narrowing, foraminal narrowing, or spondylolisthesis was documented. The Claimant's persistent back pain was found to have exacerbated, despite conservative treatment. A CT was recommended.

On [redacted], the Claimant physican stated that the Claimant suffers from a chronic degenerative back condition though would likely require a neurosurgical intervention therefore the Claimant was advised not to exercise until resolution of the problem.

On [redacted], a CT scan of the lumbar spine was performed which revealed bilateral spondylolysis at L3-L4 with circumferential protrusion of disc materal at L4-L5,

dominant towards the right and laterall producing significant foraminal narrowing on the right and lateral recess narrowing. Further, a small central disc protrusion partially calcified at L5-S1 was documented. More specifically, the protrusion was producing an anterior extradural defect which was producing minimal indentation upon the forming S1 root on the left and near impingement upon the forming root, S1 on the right.

On [redacted], the Claimant attended a follow-up neurosurgical evaluation. No relief from conservative treatment was noted. The Claimant's surgical options were a concern due to the multi-segment disease however a discogram was ordered.

On [redacted], the Claimant attended a follow-up appointment for his back pain. The Claimant's condition remained unchanged despite traction and prescribed treatment.

On [redacted], the Claimant attended a psychological evaluation/counseling. The Claimant was diagnosed with adjustment diosrder depression with a Global Assessment Functioning ("GAF") of 45. Psycho-social issues were documented as a fear of not being able to perform his occupational duties and protect himself or others as well as a fear of not be able to keep his employment thus meet his financial obligations.

On [redacted], a discogram was performed the Claimant which revealed a broad-based right lateral radial annual tear at L4-L5; significant degeneration of the disc with concentric tears and a more focal right foraminal protrusion encroaching on the right foramen but significant mass effect on the exiting right L5 nerve root at L5-S1; and bilateral spondylolysis at L3 and L4.

On [redacted], the Claimant presented to the hospital with complaints of increased back pain. The Claimant was informed that the pain was not likely due to the discogram (infection or other complication) but rather a re-exacerbation of his chronic back pain.

On [redacted], the Claimant attended a neurosurgical follow-up appointment regarding the discogram. The test showed augmentation of pain with injection at the L4-L5 and L5-S1 levels with spondylolysis bilaterally at the L3 and L4 segments. Surgical intervention was not warranted due to the risk of greater instability and potential acceleration of degenerative changes. Further, surgery would not guarantee pain alleviation. Ultimately, continued conservative management was recommended with restrictions in lifting no greater than 15 pounds with minimum bending/twisting and no climbing or running. The Claimant was limited to minimal strenuous physical activity.

On [redacted], the Claimant attended a follow-up appointment for his back pain. The Claimant was informed of the likelihood of neurosurgical intervention and conservative pain management was continued.

On [redacted], the Claimant was evaluated after complaints of frequent headaches. The Claimant was informed of a possible csf leak from the discogram and was instructed to lay down for approximately 48 hours and return if not resolved.

On [redacted], the Claimant attended a follow-up appointment noting the headaches have improved. Epidural injections were discussed and the Claimant was instructed to continue his ongoing limitations for another 6 months which included no running, minimal twisting/bending, and no lifting more than 25 pounds.

On [redacted], the Claimant attended an independednt evaluation. A review of the [redacted] MRI foundherniation of the L4-5 with fragment compressing the root with the forament. At a minimum, epidural injections were recommended as well as consideration for a laminectormy for decompression fo the root at the L4-5 level combined with a fusion of L4 to

the sacrum. The Claimant was limited to light duty activities of occasionally lifting 15 pounds with no repetitive bending, twisting, turning, and sitting/standing option every 15 to 20 minutes.

On [redacted], the Claimant's back pain was assessed. Pain on straight leg raising manuever was noted however he was able to to toe and heel walk with a normal gait. A review of the x-rays revealed spondylolysis at L3 without spondylolistheses as well as a "very dengerative" L4-5 disc with L5-S1 degenerative changes. The difficulties in performing a potenial three-level fusion were mentioned as well as the ultimate recommendation to maintain light duty limitations of ten pounds with no repetitive twisting or bending until a bone scan is performed.

In [redacted], the Claimant underwent a full body bone scan which showed mild asymmetric sclerosis and pedicle thickening on the left.

On [redacted], s-rays of the lumbar spine were taken which found lateral translational instability at L4-5 along with spondylolisthesis at the L4-5 level with instability noted on flexion and extension. An MRI was recommended as well as possible surgical intervention.

On [redacted], a MRI of the lumbar spine without contrast was performed which revealed bilateral spondylolysis at the L3-4 and L4-5 levels; borad based small to moderate right paracentral annular tear at the L4-5 level with some worsening of the disc space narrowing; and small central annular tear at the L5-S1 level.

On [redacted], a decompressive lumbar laminectomy at L4-5 with foraminotomy and bilateral posterolateral fusion at L4-S1 with rods and grafts and repair of L3 with implantable spinal fusion stimulator and bone graft was performed. The Claimant was discharged on January 31st with the final diagnoses of spondylolisthesis, L4 on L5 with

degenerative disc disease, L4 – L5 and L5 – S1 with lumbar radiculopathy and L3 pars defect. The Claimant was also diagnosed with depression.

On [redacted], the Claimant attended a post-surgery (decompression laminectomy and fusion, L4 through S1) follow-up appointment where he was diagnosed with lateral translational instability. X-rays foun all pedicle screws aligned and unchanged.

On [redacted], the Department received a completed Medical Examination Report on behalf of the Claimant. The current diagnoses were listed as spinal stenosis, lateral translational instability, spondylolisthesis, spondylolysis, and lumbar degenerative disc disease. The Claimant was found able to occasionally lift/carry 25 pounds; stand and/or walk at least 2 hours during an 8 hour workday; sit less than 6 hours during this same time period; and able to perform repetitive action with both hands/arms but unable to operate foot/leg controls with either lower extremity.

On [redacted], the Department of Veterans Affairs issued a decision which found the Claimant disabled based upon his right knee degenerative disc disease; recurrent right and left shoulder tendonitis; right and left carpal tunnel syndrome; chronic recurrent skin rash; hemorrhoids; and left ear hearing loss.

On [redacted], a Medical Examination Report was completed by the Claimant's treating physician which listed the Claiamnt's disability/expected retrun to work date as January 2010. The Claimant wa limited to occasionally lifting/carrying 10 pounds; standing and/or walking less than 2 hours during an 8 hour day with sitting less than 6 hours during this same period. The Claimant's need for a lumbar brace with internal spine stimulators for ambulation was also noted.

As previously noted, the Claimant bears the burden to present sufficient objective medical evidence to substantiate the alleged disabling impairment(s). As summarized above, the

Claimant has presented objective medical evidence establishing that he does have some physical limitations on his ability to perform basic work activities. Accordingly, the Claimant has an impairment, or combination thereof, that has more than a *de minimis* effect on the Claimant's basic work activities. Further, the impairments have lasted continuously for twelve months; therefore, the Claimant is not disqualified from receipt of MA-P benefits under Step 2.

In the third step of the sequential analysis of a disability claim, the trier of fact must determine if the Claimant's impairment, or combination of impairments, is listed in Appendix 1 of Subpart P of 20 CFR, Part 404. The Claimant asserts physical disabling impairment(s) due in part to chronic back with degenerative disc disease, neck and shoulder pain, knee pain, and arthritis. Listing 1.00 defines musculoskeletal system impairments. Disorders of the musculoskeletal system may result from hereditary, congenital, or acquired pathologic processes. 1.00A Impairments may result from infectious, inflammatory, or degenerative processes, traumatic or developmental events, or neoplastic, vascular, or toxic/metabolic diseases. 1.00A Regardless of the cause(s) of a musculoskeletal impairment, functional loss for purposes of these listings is defined as the inability to ambulate effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment, or the inability to perform fine and gross movements effectively on a sustained basis for any reason, including pain associated with the underlying musculoskeletal impairment. Inability to ambulate effectively means an extreme limitation of the ability to walk; i.e., an impairment(s) that interferes very seriously with the individual's ability to independently initiate, sustain, or complete activities. 1.00B2b (1) Ineffective ambulation is defined generally as having insufficient lower extremity function to permit independent ambulation without the use of a hand-held assistive device(s) that limits the functioning of both upper extremities. (Listing 1.05C is an exception to this general

definition because the individual has the use of only one upper extremity due to amputation of a hand.) *Id.* To ambulate effectively, individuals must be capable of sustaining a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living. 1.00B2b (2) They must have the ability to travel without companion assistance to and from a place of employment or school. . . . *Id.* When an individual's impairment involves a lower extremity uses a hand-held assistive device, such as a cane, crutch or walker, the medical basis for use of the device should be documented. 1.00J4 The requirement to use a hand-held assistive device may also impact an individual's functional capacity by virtue of the fact that one or both upper extremities are not available for such activities as lifting, carrying, pushing, and pulling. *Id.*

Categories of Musculoskeletal include:

1.02 Major dysfunction of a joint(s) due to any cause: Characterized by gross anatomical deformity (e.g. subluxation, contracture, bony or fibrous ankylosis, instability) and chronic joint pain and stiffness with signs of limitation of motion or other abnormal motion of the affected joint(s), and findings on appropriate medically acceptable imaging of joint space narrowing, bony destruction, or ankylosis of the affected joint(s). With:

A. Involvement of one major peripheral weight-bearing joint (i.e., hip, knee, or ankle), resulting in inability to ambulate effectively as defined in 1.00B2b; or

B. Involvement of one major peripheral joint in each upper extremity (i.e., shoulder, elbow, wrist, hand), resulting in inability to perform fine and gross movements effectively a defined in 1.00B2c

* * *

1.04 Disorders of the spine (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, and vertebral fracture), resulting in compromise of a nerve root (including the cauda equine) or spinal cord. With:

A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there

is involvement of the lower back, positive straight-leg raising test (sitting and supine); or

B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours; or

C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b. (See above definition)

Based upon the submitted medical documentation, the Claimant suffers from chronic pain in the knee, shoulder, back, and wrists with limited range of motion and has degenerative disc disease with spinal stenosis and nerve root compression requiring surgical intervention. Although the Claimant had surgery (after unsuccessful conservative treatment) the Claimant still experiences significant limitations. The Claimant's treating physician in June of 2009 opined that the Claimant disability has lasted and is expected to last continuously for a period of more than 12 months. Further, the Claimant requires an assistive device for effective ambulation. Ultimately, after review of the Claimant's medical records, it is found that the Claimant's impairments meet the intent and severity requirements, or are the equivalent thereof, a listed impairment with Listing 1.00 as detailed above. Accordingly, the Claimant is found disabled at Step 3 with no further analysis required.

The State Disability Assistance ("SDA") program, which provides financial assistance for disabled persons, was established by 2004 PA 344. DHS administers the SDA program purusant to MCL 400.10 *et seq.* and Michigan Administrative Code ("MAC R") 400.3151 – 400.3180. Department policies are found in PAM, PEM, and PRM. A person is considered

disabled for SDA purposes if the person has a physical or mental impairment which meets federal SSI disability standards for at least ninety days. Receipt of SSI or RSDI benefits based on disability or blindness, or the receipt of MA benefits based on disability or blindness (MA-P) automatically qualifies an individual as disabled for purposes of the SDA program.

In this case, the Claimant is found disabled for purposes of the Medical Assistance ("MA-P") program, therefore the Claimant's is found disabled for purposes of SDA benefits.

DECISION AND ORDER

The Administrative Law Judge, based upon the findings of fact and conclusions of law, finds the Claimant disabled for purposes of the Medical Assistance program and the State Disability Assistance program.

It is ORDERED:

1. The Department's determination is REVERSED.

2. The Department shall initiate review of the November 17, 2008 application to determine if all other non-medical criteria are met and inform the Claimant and his representative of the determination.

3. The Department shall supplement the Claimant any lost benefits he was entitled to receive if otherwise eligible and qualified in accordance with department policy.

4. The Department shall review the Claimant's continued eligibility in accordance department policy in February of 2010.

__/s/_____
Colleen M. Mamelka
Administrative Law Judge
For Ishmael Ahmed, Director
Department of Human Services

Date Signed: _08/19/09_____

Date Mailed: _08/20/09_____

NOTICE: Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to the Circuit within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the recip date of the rehearing decision.

CMM/jlg

cc: [redacted]